§ 108A-70.19. Short title; purpose; no entitlement.

This Part may be cited as "The Health Insurance Program for Children Act of 1998." The purpose of this Part is to provide comprehensive health insurance coverage to uninsured low-income children who are residents of this State. Coverage shall be provided from federal funds received, State funds appropriated, and other nonappropriated funds made available for this purpose. Nothing in this Part shall be construed as obligating the General Assembly to appropriate funds for the Program or as entitling any person to coverage under the Program. (1998-1, s. 1.)

§ 108A-70.20. Program established.

The Health Insurance Program for Children is established. The Program shall be administered by the Department of Health and Human Services in accordance with this Part and as required under Title XXI and related federal rules and regulations. Administration of Program benefits and claims processing shall be as provided under Part 5 of Article 3 of Chapter 135 of the General Statutes. (1998-1, s. 1.)

§ 108A-70.21. Program eligibility; benefits; enrollment fee and other cost-sharing; coverage from private plans; purchase of extended coverage.

(a)Eligibility. - The Department may enroll eligible children based on availability of funds. Following are eligibility and other requirements for participation in the Program:

(1) Children must:

a. Be under the age of 19;

b. Be ineligible for Medicaid, Medicare, or other federal government-sponsored health insurance;

c. Be uninsured;

d. Be in a family that meets the following family income requirements:

1. Infants under the age of one year whose family income is from one hundred eighty-five percent (185%) through two hundred percent (200%) of the federal poverty level;

2. Children age one year through five years whose family income is above one hundred thirty-three percent (133%) through two hundred percent (200%) of the federal

poverty level; and

3. Children age six years through eighteen years whose family income is above one hundred percent (100%) through two hundred percent (200%) of the federal poverty level;

e. Be a resident of this State and eligible under federal law; and

f. Have paid the Program enrollment fee required under this Part.

(2) Proof of family income and residency and declaration of uninsured status shall be provided by the applicant at the time of application for Program coverage. The family member who is legally responsible for the children enrolled in the Program has a duty to report any change in the enrollee's status within 60 days of the change of status.

(3) If a responsible parent is under a court order to provide or maintain health insurance for a child and has failed to comply with the court order, then the child is deemed uninsured for purposes of determining eligibility for Program benefits if at the time of application the custodial parent shows proof of agreement to notify and cooperate with the child support enforcement agency in enforcing the order.

If health insurance other than under the Program is provided to the child after enrollment and prior to the expiration of the eligibility period for which the child is enrolled in the Program, then the child is deemed to be insured and ineligible for continued coverage under the Program. The custodial parent has a duty to notify the Department within 10 days of receipt of the other health insurance, and the Department, upon receipt of notice, shall disenroll the child from the Program. As used in this paragraph, the term "responsible parent" means a person who is under a court order to pay child support.

(4) Except as otherwise provided in this section, enrollment shall be continuous for one year. At the end of each year, applicants may reapply for Program benefits.

((b) Benefits. - Except as otherwise provided for eligibility,

fees, deductibles, copayments, and other cost-sharing charges, health benefits coverage provided to children eligible under the Program shall be equivalent to coverage provided for dependents under the North Carolina Teachers' and State Employees' Comprehensive Major Medical Plan, including optional prepaid plans. Prescription drug providers shall accept as payment in full, for outpatient prescriptions filled, ninety percent (90%) of the average wholesale price for the prescription drug or the amounts published by the Centers for Medicare and Medicaid Services plus a dispensing fee of five dollars and sixty cents ($5.60) per prescription for generic drugs and four dollars ($4.00) per prescription for brand name drugs. All other health care providers providing services to Program enrollees shall accept as payment in full for services rendered the maximum allowable charges under the North Carolina Teachers' and State Employees' Comprehensive Major Medical Plan for services less any copayments assessed to enrollees under this Part. No child enrolled in the Plan's self-insured indemnity program shall be required by the Plan to change health care providers as a result of being enrolled in the Program.

In addition to the benefits provided under the Plan, the following services and supplies are covered under the Health Insurance Program for Children established under this Part:

(1) Dental: Oral examinations, teeth cleaning, and scaling twice during a 12-month period, full mouth X-rays once every 60 months, supplemental bitewing X-rays showing the back of the teeth once during a 12-month period, fluoride applications twice during a 12-month period, fluoride varnish, sealants, simple extractions, therapeutic pulpotomies, prefabricated stainless steel crowns, and routine fillings of amalgam or other tooth-colored filling material to restore diseased teeth. No benefits are to be provided for services under this subsection that are not performed by or upon the direction of a dentist, doctor, or other professional provider approved by the Plan nor for services and materials that do not meet the standards accepted by the American Dental Association.

(2) Vision: Scheduled routine eye examinations once every 12 months, eyeglass lenses or contact lenses once every 12 months, routine replacement of eyeglass frames once every 24 months, and optical supplies and solutions when needed. Optical services, supplies, and solutions must be obtained

from licensed or certified opthamologists, ophthalmologists, optometrists, or optical dispensing laboratories. Eyeglass lenses are limited to single vision, bifocal, trifocal, or other complex lenses necessary for a Plan enrollee's visual welfare. Coverage for oversized lenses and frames, designer frames, photosensitive lenses, tinted contact lenses, blended lenses, progressive multifocal lenses, coated lenses, and laminated lenses is limited to the coverage for single vision, bifocal, trifocal, or other complex lenses provided by this subsection. Eyeglass frames are limited to those made of zylonite, metal, or a combination of zylonite and metal. All visual aids covered by this subsection require prior approval of the Plan. Upon prior approval by the Plan, refractions may be covered more often than once every 12 months.

(3) Hearing: Auditory diagnostic testing services and hearing aids and accessories when provided by a licensed or certified audiologist, otolaryngologist, or other hearing aid specialist approved by the Plan. Prior approval of the Plan is required for hearing aids, accessories, earmolds, repairs, loaners, and rental aids.

The Department may provide services to children aged birth through five years enrolled in the Program through the State Medical Assistance managed care program. Services provided through the managed care program shall be paid from Program funds.

(c) Annual Enrollment Fee. - There shall be no enrollment fee for Program coverage for enrollees whose family income is at or below one hundred fifty percent (150%) of the federal poverty level. The enrollment fee for Program coverage for enrollees whose family income is above one hundred fifty percent (150%) of the federal poverty level shall be fifty dollars ($50.00) per year per child with a maximum annual enrollment fee of one hundred dollars ($100.00) for two or more children. The enrollment fee shall be collected by the county department of social services and retained to cover the cost of determining eligibility for services under the Program. County departments of social services shall establish procedures for the collection of enrollment fees.

(d) Cost-Sharing. - There shall be no deductibles, copayments, or other cost-sharing charges for families covered under the Program whose family income is at or below one hundred

fifty percent (150%) of the federal poverty level.
level, except that fees for outpatient prescription drugs are applicable and shall be one dollar ($1.00) for each outpatient generic prescription drug and for each outpatient brand-name prescription drug for which there is no generic substitution available. The fee for each outpatient brand-name prescription drug for which there is a generic substitution available is three dollars ($3.00). Families covered under the Program whose family income is above one hundred fifty percent (150%) of the federal poverty level shall be responsible for copayments to providers as follows:

(1) Five dollars ($5.00) per child for each visit to a provider, except that there shall be no copayment required for well-baby, well-child, or age-appropriate immunization services;

(2) Five dollars ($5.00) per child for each outpatient hospital visit;

(3) One dollar ($1.00) fee for each outpatient generic prescription drug and for each outpatient brand-name prescription drug for which there is no generic substitution available. The fee for each outpatient brand-name prescription drug for which there is a generic substitution available is ten dollars ($10.00).

(4) Twenty dollars ($20.00) for each emergency room visit unless:

a. The child is admitted to the hospital, or

b. No other reasonable care was available as determined by the Claims Processing Contractor of the North Carolina Teachers' and State Employees' Comprehensive Major Medical Plan.

Copayments required under this subsection for prescription drugs apply only to prescription drugs prescribed on an outpatient basis.

(e) Cost-Sharing Limitations. - The total annual aggregate cost-sharing, including fees, with respect to all children in a family receiving Program benefits under this Part shall not exceed five percent (5%) of the family's income for the year involved. To assist the Department in monitoring and ensuring that the limitations of this subsection are not exceeded, the Executive Administrator and Board of Trustees of the North Carolina Teachers' and State Employees' Comprehensive Major Medical Plan shall provide data to the Department showing cost-sharing paid by Program enrollees.

(f) Coverage From Private Plans. - The Department shall, from funds available for the Program, pay the cost for dependent

coverage provided under a private insurance plan for persons eligible for coverage under the Program if all of the following conditions are met:

(1) The person eligible for Program coverage requests to obtain dependent coverage from a private insurer in lieu of coverage under the Program and shows proof that coverage under the private plan selected meets the requirements of this subsection;

(2) The dependent coverage under the private plan is actuarially equivalent to the coverage provided under the Program and the private plan does not engage in the exclusive enrollment of children with favorable health care risks;

(3) The cost of dependent coverage under the private plan is the same as or less than the cost of coverage under the Program; and

(4) The total annual aggregate cost-sharing, including fees, paid by the enrollee under the private plan for all dependents covered by the plan, do not exceed five percent (5%) of the enrollee's family income for the year involved.

The Department may reimburse an enrollee for private coverage under this subsection upon a showing of proof that the dependent coverage is in effect for the period for which the enrollee is eligible for the Program.

(g) Purchase of Extended Coverage. - An enrollee in the Program who loses eligibility due to an increase in family income above two hundred percent (200%) of the federal poverty level and up to and including two hundred twenty-five percent (225%) of the federal poverty level may purchase at full premium cost continued coverage under the Program for a period not to exceed one year beginning on the date the enrollee becomes ineligible under the income requirements for the Program. The same benefits, copayments, and other conditions of enrollment under the Program shall apply to extended coverage purchased under this subsection.

(h) No State Funds for Voluntary Participation. - No State or federal funds shall be used to cover, subsidize, or otherwise offset the cost of coverage obtained under subsection (g) of this section."

fees, deductibles, copayments, and other cost-sharing charges, health benefits coverage provided to children eligible under the Program shall be equivalent to coverage provided for dependents under the North Carolina Teachers' and State Employees' Comprehensive Major Medical Plan, including optional prepaid plans. Prescription drug providers shall accept as payment in

full, for outpatient prescriptions filled, ninety percent (90%) of the average wholesale price for the prescription drug or the amounts published by the Centers for Medicare and Medicaid Services plus a dispensing fee of five dollars and sixty cents ($5.60) per prescription for generic drugs and four dollars ($4.00) per prescription for brand name drugs. All other health care providers providing services to Program enrollees shall accept as payment in full for services rendered the maximum allowable charges under the North Carolina Teachers' and State Employees' Comprehensive Major Medical Plan for services less any copayments assessed to enrollees under this Part. No child enrolled in the Plan's self-insured indemnity program shall be required by the Plan to change health care providers as a result of being enrolled in the Program.

§ 108A-70.22. Allocation of federal and State funds for Program; consultation with Joint Legislative Health Care Oversight Committee.

The Department of Health and Human Services, after having consulted with and received advice from the Joint Legislative Health Care Oversight Committee established under G.S. 120-70.110, shall from total funds available to the Department for Program implementation, allocate and adjust, as needed, funds to pay the North Carolina Teachers' and State Employees' Major Medical Plan in accordance with G.S. 108A-70.23 and Part 5 of Article 3 of Chapter 135 of the General Statutes, and funds to pay for eligible services provided for children with special needs in accordance with G.S. 108A-70.23. (1998-1, s. 1.)

§ 108A-70.23. Services for children with special needs established; definition; eligibility; services; limitation; recommendations; no entitlement.

(a)[Special Needs Services Authorized.-] The Department shall, from federal funds received and State funds appropriated for the Program, pay for services for children with special needs as authorized under this section. As used in this section, the term "children with special needs" or "special needs child" means children who have been diagnosed as having one or more of the following conditions which in the opinion of the diagnosing physician (i) is likely to continue indefinitely, (ii) interferes with daily routine, and (iii) require extensive medical intervention and extensive family management:

(1) Birth defect, including genetic, congenital, or acquired disorders;
(2) Developmental disability as defined under G.S. 122C-3;
(3) Mental or behavioral disorder; or

(4) Chronic and complex illnesses.

(b) Eligibility for Services. - In order to be eligible for services under this section a special needs child must be enrolled in the Program.

("(c)Services Provided. - The services authorized to be provided to children eligible under this section are as follows:

(1) The same level of services as provided for special needs children under the Medical Assistance Program as authorized in the Current Operations Appropriations Act except that that:

a. no No services for long-term care shall be provided under this section, and section;

b. except that services Services for respite care shall be provided only under emergency circumstances; and

c. The Department may limit services for special needs children after consultation with the Commission on Children with Special Health Care Needs.

(2) Only those services eligible under this section that are not covered or otherwise provided under Part 5 of Article 3 of Chapter 135 of the General Statutes."

(d) Limitation. - Funds may be expended for services under this section only if the special needs child is enrolled in the Program, the services provided under this section are not provided under Part 5 of Article 3 of Chapter 135 of the General Statutes, and the child meets the definition of a special needs child under this section.

(e) Case Management Services. - The Department shall develop procedures for the provision of case management services by the Department to eligible special needs children. Case management services shall be developed to ensure to the maximum extent possible that services are provided in the most efficient and effective manner considering the special needs of the child. The cost of providing case management services for children with special needs shall be paid from funds available for services under this section.

(f) Recommendations by Commission on Children With Special Health Care Needs. - In implementing this section the Department shall consider the recommendations of the Commission on Children With Special Health Care Needs established under Article 71 of

Chapter 143 of the General Statutes. The Department, in consultation with the Commission on Children With Special Health Care Needs shall develop procedures for providing respite care services under emergency circumstances.

(g) No Entitlement. - Nothing in this section shall be construed as entitling any person to services under this section. (1998-1, s. 1.)

§ 108A-70.24. Claims processing; payments.

(a)The North Carolina Teachers' and State Employees' Comprehensive Major Medical Plan shall be responsible for the administration and processing of claims for benefits under the Program, as provided under Part 5 of Article 3 of Chapter 135 of the General Statutes.

(b) The Department shall, from State and federal appropriations, and from any other funds made available for this purpose, make premium payments to the North Carolina Teachers' and State Employees' Comprehensive Major Medical Plan as determined by the Plan for its administration, claims processing, and other services authorized to provide coverage for acute medical care to children eligible for benefits under this Part.

(c) The North Carolina Teachers' and State Employees' Comprehensive Major Medical Plan shall also be responsible for the administration and processing of claims for benefits provided under G.S. 108A-70.23 and not covered by Part 5 of Article 3 of Chapter 135 of the General Statutes. Such claims payments shall be made against accounts maintained by the Department. (1998-1, s. 1.)

§ 108A-70.25. State Plan for Health Insurance Program for Children.

The Department shall develop and submit a State Plan to implement "The Health Insurance Program for Children" authorized under this Part to the federal government as application for federal funds under Title XXI. The State Plan submitted under this Part shall be developed by the Department only as authorized by and in accordance with this Part. No provision in the State Plan submitted under this Part may expand or otherwise alter the scope or purpose of the Program from that authorized under this Part. The Department shall include in the State Plan submitted only those items required by this Part and required by the federal government to qualify for federal funds under Title XXI and necessary to secure the State's federal fund allotment

for the applicable fiscal period. Except as otherwise provided in this section, the Department shall not amend the State Plan nor submit any amendments thereto to the federal government for review or approval without the specific approval of the General Assembly. In the event federal law requires that an amendment be made to the State Plan and further requires that the amendment be submitted or implemented within a time period when the General Assembly is not and will not be in session to approve the amendment, then the Department may submit the amendment to the federal government for review and approval without the approval of the General Assembly. Prior to submitting an amendment to the federal government without General Assembly approval as authorized in this section, the Department shall report the proposed amendment to the Joint Legislative Health Care Oversight Committee and to members of the Joint Appropriations Subcommittee on Health and Human Services. The report shall include an explanation of the amendment, the necessity therefor, and the federal time limits required for implementation of the amendment. (1998-1, s. 1.)

§ 108A-70.26. Application process; outreach efforts; appeals.

(a)Application. - The Department shall use an application form for the Program that is concise, relatively easy for the applicant to comprehend and complete, and only as lengthy as necessary for identifying applicants, determining eligibility for the Program or Medicaid, and providing information to applicants on requirements for application submission and proof of eligibility. Application forms shall be obtainable from public health departments and county departments of social services. Applications shall be processed by the county department of social services and may be submitted by mail. The Department may adopt rules for the submission and processing of applications and for securing the proof of eligibility for benefits under this Part.

The application form for the Program shall have printed on it or attached to it a notice stating substantially: "The Health Insurance Program for Children is a federally and State funded program that may be discontinued if federal funds are not provided for its continuation."

(b) Outreach Efforts. - The Department shall adopt procedures to ensure that the Program is adequately publicized statewide and to comply with federal outreach requirements. The Department shall make information about the Program available through the Internet and shall explore the feasibility of securing a 24-hour

toll-free telephone number to facilitate access to Program information. In order to avoid duplication of efforts, in developing outreach procedures the Department shall establish system linkages to ensure the collaboration and coordination of information between and among the Program and such ongoing programs and efforts as:

WIC Program.
Maternal and Child Health Block Grant.
Children's Special Health Services.
Smart Start.
Head Start.

The Department shall seek private and federal grant funds for outreach activities. The Department shall also seek the participation of the private sector in providing no-cost or low-cost avenues for publicizing the Program in local communities and statewide. The Department may work with the State Health Plan Purchasing Alliance Board to develop programs that utilize the expertise and resources of the Alliances in outreach activities to employees of small businesses.

(c) Appeals. - A person who is dissatisfied with the action of a county department of social services with respect to the determination of eligibility for benefits under the Program may appeal the action in accordance with G.S. 108A-79. (1998-1, s. 1.)

§ 108A-70.27. Data collection; reporting.

(a)The Department shall ensure that the following data are collected, analyzed, and reported in a manner that will most effectively and expeditiously enable the State to evaluate Program goals, objectives, operations, and health outcomes for children:

(1) Number of applicants for coverage under the Program;
(2) Number of Program applicants deemed eligible for Medicaid;
(3) Number of applicants deemed eligible for the Program, by income level, age, and family size;
(4) Number of applicants deemed ineligible for the Program and the basis for ineligibility;
(5) Number of applications made at county departments of social services, public health departments, and by mail;
(6) Total number of children enrolled in the Program to date and for the immediately preceding fiscal year;
(7) Total number of children enrolled in Medicaid

through the Program application process;

(8) Trends showing the Program's impact on hospital utilization, immunization rates, and other indicators of quality of care, and cost-effectiveness and efficiency;

(9) Trends relating to the health status of children;

(10) Other data that would be useful in carrying out the purposes of this Part.

(b) The Department shall report annually to the Joint Legislative Health Care Oversight Committee and shall provide a copy of the report to the Joint Appropriations Subcommittees on Health and Human Services. The report shall include:

(1) Data collected as required under subsection (a) of this section and an analysis thereof giving trends and projections for continued Program funding;

(2) Program areas working most effectively and least effectively;

(3) Performance measures used to ensure Program quality, fiscal integrity, ease of access, and appropriate utilization of preventive and medical care;

(4) Effectiveness of system linkages in addressing access, quality of care, and Program efficiency;

(5) Recommended changes in the Program necessary to improve Program efficiency and effectiveness;

(6) Any other information requested by the Committee pertinent to the provision of health insurance for children and the implementation of the Program.

(c) The Executive Administrator and Board of Trustees of the North Carolina Teachers' and State Employees' Major Medical Plan ("Plan") shall provide to the Department data required under this section that are collected by the Plan. Data shall be reported by the Plan in sufficient detail to meet federal reporting requirements under Title XXI. The Plan shall report periodically to the Joint Legislative Health Care Oversight Committee claims processing data for the Program and any other information the Plan or the Committee deems appropriate and relevant to assist the Committee in its review of the Program. (1998-1, s. 1.)

§ 108A-70.28. Fraudulent misrepresentation.

(a)It shall be unlawful for any person to knowingly and willfully, and with intent to defraud, make or cause to be made a false statement or representation of a material fact in an application for coverage under this Part or intended for use in

determining eligibility for coverage.

(b) It shall be unlawful for any applicant, recipient, or person acting on behalf of the applicant or recipient to knowingly and willfully, and with intent to defraud, conceal, or fail to disclose any condition, fact, or event affecting the applicant's or recipient's initial or continued eligibility to receive coverage or benefits under this Part.

(c) It is unlawful for any person knowingly, willingly, and with intent to defraud, to obtain or attempt to obtain, or to assist, aid, or abet another person, either directly or indirectly, to obtain money, services, or any other thing of value to which the person is not entitled as a recipient under this Part, or otherwise to deliberately misuse a Program identification card. This misuse includes the sale, alteration, or lending of the Program identification card to others for services and the use of the card by someone other than the recipient to receive or attempt to receive Program coverage for services rendered to that individual.

Proof of intent to defraud does not require proof of intent to defraud any particular person.

(d) A person who violates a provision of this section shall be guilty of a Class I felony.

(e) For purposes of this section the word "person" includes any natural person, association, consortium, corporation, body politic, partnership, or other group, entity, or organization. (1998-1, s. 1.)